InterContinental Washington DC- The Wharf
801 Warf Street SW, Washington, DC 20024
December 6, 2018
1:00-2:00pm

Executive Session
Meeting Summary

FICEMS Members in Attendance

Department of Health and Human Services (HHS)
Adam Boehler, Director, Center for Medicare and Medicaid Services (CMS), Deputy Administrator and Director, Center for Medicare and Medicaid Innovation
Edward J. Gabriel, MPA, Deputy Assistant Secretary for Incident Command and Control, Assistant Secretary for Preparedness and Response (ASPR)
Theresa Morrison-Quinata, Health Resources and Services Administration
Jean Sheil, Director, Emergency Preparedness and Response Operations, (CMS)

Department of Homeland Security (DHS)
G. Keith Bryant, US Fire Administration
Duane Caneva, MD, Chief Medical Officer

Department of Transportation (DOT)
Heidi King, Vice Chair, Deputy Administrator and Acting Administrator, National Highway Traffic Safety Administration (NHTSA)

Federal Communications Commission (FCC)
David Furth, Deputy Bureau Chief, Public Safety and Homeland Security Bureau

State EMS Directors
Joseph Schmider, State EMS Director, Texas

FICEMS Staff in Attendance

Department of Defense (DOD)
Elizabeth Fudge, BSN, MPH

Department of Health and Human Services (HHS)
Sean Andrews, MPH, (ASPR)

Department of Transportation (DOT)
Dave Bryson (NHTSA)
Eric Chaney (NHTSA)
Jon Krohmer, MD (NHTSA)
Gamunu Wijetunge (NHTSA)

Welcome, Introductions, Opening Remarks

Ed Gabriel, MPA, FICEMS Chair

Mr. Gabriel called the executive meeting of the Federal Interagency Committee on Emergency Medical Services (FICEMS) to order at 1:08pm. He expressed his pleasure at being able to serve as the Chair of the committee over the years. He noted the productivity of FICEMS, especially the progress made on EMS Agenda 2050.

Briefing on Emergency Triage, Treat and Transport (ET^3) Model

Adam Boehler, Deputy Administrator and Director, Center for Medicare and Medicaid Innovation

Mr. Boehler explained that the Center for Medicare and Medicaid Innovation (CMMI) works with the CMS to develop and test innovative health care payment and service delivery models. The goal is to test and identify models that will decrease costs and improve the quality of care.

The CMMI is currently examining 30 different models that align incentives from both the health care service and payment perspective. For example, an incentive for payment of EMS delivery of a patient to a hospital currently does not allow compensation when the best option for the patient is delivery to a physician's office or urgent care center. The CMMI is taking a broad approach to try and identify ways to pay providers for selecting the best care setting for patients. Mr. Boehler added that they are trying to establish a nurse phone line for patients as a strategy to reduce calls to EMS for non-emergent issues. Recent information from the New York Fire Department showed that 30 to 35% of patients taken to a hospital by EMS did not need emergency department or hospital care. A recognized challenge will be to increase patient awareness about emergency care while redirecting them to other health care resources (e.g., a nurses line, urgent care center, EMS treatment in place, etc). It is critical for patients with time-sensitive emergencies (e.g., MI, stroke, etc) to receive hospital care as quickly as possible. Redirecting less emergent issues could facilitate more rapid delivery of care. The CMMI is also exploring ways to pay for emergency care provided at urgent care centers and doctor's offices. The CMMI has noted a large amount of community interest in such programs.

Dr. Caneva asked how a successful innovative health care payment or service delivery model studied by CMMI becomes the standard of care in the healthcare sector. Mr. Boehler explained that when CMS establishes a standard of care or payment model it often becomes the standard of care in the overall health care system. The CMMI work to develop and test innovative health care payment and service delivery models is different from the work done by CMS and is an important distinction. CMMI gathers input from external and internal stakeholders to determines which projects to test. The aim is to test programs for two to five years

that would have the greatest impact on cost and quality of care. If they are successful, then they can be certified and implemented across the country as de factor public policy.

Dr. Caneva followed up with a concern that a government agency, such as the CMMI, is setting standards across the entire healthcare sector. He proposed that other models may exist, including having private industry develop standards with some government oversight. Mr. Boehler added that the CMMI has the authority and mission to test different health care payment systems and service delivery models to see if they reduce costs or improve quality of care before they become policy. It is critical to see if these systems work before they are implemented.

Mr. Schmider asked the CMMI to include a public education component of the ET^3 model if it is rolled out. Health care providers know that it is less costly to treat patients at urgent care centers and physician offices. However, the general public needs education on which types of emergencies are best handled in the various emergency and urgent care settings. Additionally, he suggested including an incentive program for state EMS to take patients to other health care locations. Currently, reimbursement for ambulance transportation is tied to the delivery of patients to emergency departments. Mr. Boehler shared that the CMMI has studied several models, including the MedStar model, and is encouraged by the success of those systems in utilizing other health care locations with good patient outcomes. Mr. Andrews added that EMS providers also need education on the reimbursement system.

Dr. Krohmer shared that a number of models use basic and advanced EMS providers under protocols or with online medical supervision from a physician to provide emergency services. He asked if the CMMI is exploring EMS reimbursement for those types of services. Mr. Boehler said the CMMI is currently studying a payment model that includes having nurse practitioners supervise EMS providers directly or via telemedicine.

Mr. Gabriel expressed concern about liability with the type of emergency care model where patients are taken to urgent care centers or physician offices for urgent care. Some state and local medical directors have had issues with liability in large programs similar to this. The CMMI should consider how to proactively manage the liability of untoward outcomes. Additionally, Mr. Gabriel offered several other suggestions for consideration as the CMMI studies this program. The proposed system provides a standardization to EMS care that does not currently exist. Larger EMS systems have thousands of personnel and standardized treatment guidelines. Volunteer EMS programs have fairly brief training and likely will not have access to a nurse practitioner for oversight. He suggested examining the unique differences and challenges this program would pose to various EMS settings (ie, urban vs. rural communities; municipal EMS systems vs. private MedStar EMS services, etc).

Dr. Krohmer emphasized that FICEMS was created in response to this type of program. He offered for FICEMS to participate with the CMMI and for members of Mr. Boehler's team to participate with a technical group to share ideas, perspectives and best practices. FICEMS is an avenue to facilitate dialogue with federal players. Mr. Boehler welcomed the opportunity to interact with FICEMS and utilize the expertise of the executive committee members.

Mr. Gabriel welcomed the opportunity to dialogue about this or other CMMI programs and invited Mr. Boehler to future FICEMS meetings.

Revision of the National EMS Scope of Practice Model and the National EMS Education Standards

Dave Bryson, NHTSA Office of EMS

Mr. Bryson reported that many federal partners participated in creating the revised standards and the final document will be posted on www.EMS.gov in December 2018. The National Association of State EMS Officials (NASEMSO) led the effort to establish the first edition of the educational standards that was released in 2007.

The premise of this project is that individuals delivering EMS require education on core content, certification and testing, and licensure and credentialing in order to work as an EMS provider. The National EMS Scope of Practice defines the national licensure levels for EMS personnel. States retain the right to determine what is necessary for state licensure and may establish more stringent requirements.

The four current levels of EMS personnel will remain:

- Emergency Medical Responder (EMR)
- Emergency Medical Technician (EMT)
- Advanced EMT (AEMT)
- Paramedic

The team conducted systematic reviews of the following topics:

- Use of narcotic antagonists
- Hemorrhage control in trauma
- Therapeutic hypothermia in cardiac arrest
- Continuous positive airway pressure (CPAP)/Bilevel positive airway pressure (BiPAP)
- Pharmacological pain management

The team did not adopt the use of targeted temperature management in out-of-hospital cardiac arrest in the prehospital setting.

The expert panel recommended that:

- All levels of personnel be able to administer narcotic antagonists, utilize tourniquets, and provide wound packing

- EMTs, AEMTs and paramedics provide CPAP on adults (≥13 years of age)
- AEMTs and paramedics administer parenteral non-steroidal medications and opiates
- EMTs, AEMTs, and paramedics administer oral over the counter (OTC) analgesics for pain or fever

The following were deleted from the scope of practice model:

- Military AntiShock Trousers (MAST)/Pneumatic AntiShock Garment (PASG)
- Spinal 'immobilization' terminology was revised
- Demand valves
- Carotid massage
- Automated transport ventilators at the EMT level (deferred to a decision by the medical director)
- 'Assisting' patients with their own prescribed medications

Key additions to the EMR scope of practice include:

- The administration of narcotic antagonists
- Hemorrhagic control with tourniquets and wound packing
- Spinal motion restriction with cervical collars
- Basic splinting for suspected extremity fractures

Key additions to the EMT scope of practice include:

- Administration of beta-agonists, anticholinergics and oral OTC analgesics for pain or fever
- Blood glucose monitoring
- CPAP
- Pulse oximetry
- Telemetric monitoring devices and transmission of clinical data, including video data

Key additions to the AEMT scope of practice include:

- High-flow nasal cannula
- Expanded use of OTC medications

The RedFlash Group was contracted to publish a white paper on several other special topics. They will take the information from the scope of practice model and make changes for all 4 levels of EMS personnel by 2020.

Several committee members asked about the role of advanced degrees for EMS providers. Mr. Bryson said that the team did not discuss the requirement for advanced degrees since they did not feel it was in the prevue of the scope of practice. Mr. Andrews added that EMS 2050 did not include a bachelor's degree as a requirement for EMS providers.

Ms. Fudge asked what considerations are going to be made for military EMS personnel when they transition to civilian service. She proposed that national certification of military personnel would provide a seamless transition to civilian employment in any state. Mr. Schmider added that Texas has a transition program that provides military personnel with a registration card that allows employment in any state. Dr. Caneva added that some universities award 2 years of college credit for military EMS/EMT experience. Mr. Gabriel commented that many military personnel may need supplemental pediatric training as they transition to civilian service in the general community.

Revision of the FICEMS Strategic Plan

Gam Wijetunge, NHTSA Office of EMS

Mr. Wijetunge reported that the FICEMS staff are currently working to revise the FICEMS Strategic Plan. The present document has driven the FICEMS subcommittee work from December 2013 until December 2018.

The vision of the Strategic Plan is:

- To establish a Federal interagency committee that enhances coordination and ensures the strategic alignment of EMS priorities among Federal agencies to ensure quality patient care

The mission is:

- To ensure coordination among Federal agencies supporting local, regional, state, and tribal and territorial EMS and 911 systems to improve the delivery of EMS throughout the nation

The overarching goal is:

- To work to achieve the six EMS system goals described in this plan by coordinating interagency policies, programming, and messaging, as well as soliciting and integrating stakeholder input from across the EMS community

He added that the team will determine what should remain in the current document, what may be missing, and what should be revised. The ad hoc revision committee includes Sean Andrews (ASPR), Eric Chaney (NHTSA), Max Sevareid (NHTSA), and Gam Wijetunge (NHTSA) who report back to the working group monthly with proposed edits. Additional members will be added as needed. The team may contract a medical writer to help draft the revised document.

The committee is trying to determine how to use the strategic plan to drive EMS Agenda 2050 and identify an overarching goal on which FICEMS should focus in the next five years.

Mr. Gabriel adjourned the meeting at 1:58pm.